Bureau of Health Care Quality and Compliance

		(X1) PROVIDER/SUPPLIER/C		(X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLE				
	NVS5423AGC			A. BUILDING B. WING		03/05	) 8/2011	
NAME OF PR	OVIDER OR SUPPLIER	NVOOTZOAGO	STREET ADD	<b>I</b> RESS, CITY, STA	ATE, ZIP CODE	1 03/0	0/2011	
EYCELLENT ADULT CARE SERVICES			8280 HICKA LAS VEGAS	AM AVE S, NV 89129				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE DSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
Y 000	Initial Comments			Y 000				
	The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.  This Statement of Deficiencies was generated as a result of an complaint investigation conducted in your facility on 3/8/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.  The facility is licensed for ten (10) Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness and/or persons with chronic illnesses. The census at the time of the survey was four. Four resident files were reviewed and one employee file was reviewed.  Complaint #NV00027733 was substantiated. See Tag Y072, Y895, Y103, Y105.  Additional deficiencies were identified and cited. See Tag Y878, Y920 and Y923.							
			ted.					
Y 072 SS=E	2 449.196(3)(a-c) Qualifications of Caregiver-Med Training		Y 072					
	facility in the administ medication, including over-the-counter med supplement, the care (a) Before assisting a administration of a me	, without limitation, an lication or dietary giver must: resident in the						

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

AND DUAN OF CODDECTION		(X1) PROVIDER/SUPPLIER/O		1` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
	NVS5423AGC			B. WING	·		C <b>08/2011</b>	
			STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	1 00/	00,2011	
			8280 HICK LAS VEGA	AM AVE S, NV 89129				
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Y 072	Continued From page	e 1		Y 072				
	Continued From page 1 subsection 6 of NRS 449.037, which must include at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training, and obtain a certificate acknowledging the completion of such training; (b) Receive annually at least 8 hours of training in the management of medication and provide the residential facility with satisfactory evidence of the content of the training and his or her attendance at the training program developed by the administrator of the residential facility pursuant to paragraph (e) of subsection 1 of NAC 449.2742; and		ent of urs of a of ng; ning ry is or d by NAC					
	prior to passing medic	ation management trair cations (Employee #1).						
	Severity: 2 Scope: 2	2						
	449.200(1)(d) Person	inel File - NAC 441A /		Y 103				

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM			(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	NIVEE 422 A C C			B. WING			C
NAME OF PR	NAME OF PROVIDER OR SUPPLIER			<b> </b> RESS, CITY, STA	TE, ZIP CODE	03	/08/2011
EXCELLENT ADULT CARE SERVICES			8280 HICK	AM AVE S, NV 89129			
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Y 103	Continued From page	e 2		Y 103			
	a separate personnel member of the staff o	se provided in subsection file must be kept for ear of a facility and must incomment ates required pursuant of for the employee.	ach lude:				
	This Regulation is not met as evidenced by: Based on record review on 3/8/11, the facility failed to ensure 1 of 1 employees complied with NAC 441A.375 regarding tuberculosis (TB) testing for the protection of all residents (Employee #1 - failed to have evidence of a second step TB test).  This was a repeat deficiency from the 9/21/10 and 1/22/10 State Licensure surveys.  Severity: 2 Scope: 3		y				
			0				
Y 105 SS=F	449.200(1)(f) Personr	nel File - Background C	heck	Y 105			
	a separate personnel member of the staff o	se provided in subsection file must be kept for ear of a facility and must inclinate with NRS 449.17	ach lude:				
	This Regulation is no Based on record revie failed to ensure 1 of 1						

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 03/08/2011		
	NVS5423AGC			A. BUILDING B. WING				
			STREET ADD	RESS CITY STAT	TE ZIP CODE	03	708/2011	
EXCELLENT ADULT CARE SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE  8280 HICKAM AVE  LAS VEGAS, NV 89129						
	T		2710 12071					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIC			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
Y 105	Continued From pag	e 3		Y 105				
	to 449.188 (Employe have evidence of a s statement).  This was a repeat de	igned criminal history eficiency from the 9/21/1	0,					
	5/13/10 and 1/22/10 State Licensure surveys.							
	Severity: 2 Scope:	3						
Y 878 SS=E	Y 878 449.2742(6)(a)(1) Medication / Change orde		r	Y 878				
	the physician. If a ph the amount or times administered to a res	ation prescribed by a diministered as prescribe hysician orders a chang medication is to be sident: sponsible for assisting in medication shall:	e in					
	Based on record revi the facility failed to en received medications Atrovent Inhaler one 90 micrograms (mcg medication was with however the medicat March 2011 medicat Employee #1 stated	ot met as evidenced by iew and interview on 3/8 nsure that 1 of 4 residers as prescribed (Reside puff twice a day and Pr) one puff twice a day. the resident's medication was not listed on thion administration recorbe did not administer the sident, the facility failed	8/11, nts nt #3- o Air The ons, e d.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
AND I LAN O	CONNECTION	IDENTIFICATION NUMB	ER:	A. BUILDING						
		NVS5423AGC		B. WING		03	C / <b>08/2011</b>			
NAME OF PR	OVIDER OR SUPPLIER	11100120/100	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		700/2011			
	8:			EET ADDRESS, CITY, STATE, ZIP CODE  0 HICKAM AVE						
EXCELLE	NT ADULT CARE SERV	ICES	LAS VEGA	S, NV 89129						
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO		(X5)			
PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY			PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		COMPLETE DATE			
17.0			,	17.0	DEFICIENCY)					
Y 878	Continued From pag	ie 4		Y 878						
	_	e order for the medication	nne)							
	provide a discontinu	e order for the inedicate	) i i 3 j .							
	· · · · · · · · · · · · · · · · · · ·	eficiency from the 2/23/1								
		1/22/10 State Licensure								
	surveys.									
	Severity: 2 Scope: 2									
	449.2744(1)(b)(1) Medication / MAR			Y 895						
SS=C										
	NAC 449.2744									
	The administrator of a residential facility that provides assistance to residents in the administration of medication shall maintain:									
		nedication administered	to							
	each resident. The									
		edication administered;	. was							
	(2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and (4) Instructions for administering the medication to the resident that reflect the current order or prescription of the resident's physician.									
		ot met as evidenced by iew on 3/8/11, the facilit								
		new on 3/8/11, the facilit medication administration								
	record (MAR) was accurate for 4 of 4 residents									

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY  COMPLETED	
7.1.12 . 27.1.1 0		IDENTIFICATION NOINBERG		A. BUILDING	<u> </u>	C	
	NVS5423AGC B. WING		03	/08/2011			
NAME OF PROVIDER OR SUPPLIER STREET			STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
EVACULE	NT 4 DUU T 0 4 DE 0 E DV	1050	8280 HICK	AM AVE			
EXCELLE	NT ADULT CARE SERV	ICES	LAS VEGA	S, NV 89129			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMAT		PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A		COMPLETE DATE
IAG				IAG	DEFICIENCY)		
Y 895	Continued From page	9.5		Y 895			
1 000				1 000			
	(Resident #1, #2, #3	and #4).					
	This was a reneat de	ficiency from the 9/21/1	0				
	State Licensure surve						
		•					
	Severity: 1 Scope:	: 3					
Y 920 SS=F	449.2748(1) Medicat	ion Storage		Y 920			
00 1							
	NAC 449.2748						
	1. Medication, includi	ing, without limitation, a	ny				
	over-the-counter med	•					
	stored at a residentia						
	facility must be stored						
	area that is cool and	=					
	caregivers employed shall ensure that any						
	medical or diagnostic						
	may be misused or a						
	resident or any other						
	person is protected. I						
	external use only mu						
	locked area separate						
	medications. A reside	•					
	of administering medication to himself without supervision may keep his medication in his room if the						
	medication is kept in						
	container for which the						
	been provided a key.	-					
	This Regulation is no	ot met as evidenced by					
	_	n on 3/8/11, the facility					
		for 2 of 4 residents and					
	Employee #1 in a loc	ked area (Resident #2	and				
	#4 - medications wer	e observed in an unlocl	ked				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
				A. BUILDING  B. WING		С		
	NVS5423AGC			03/08/201				
NAME OF PROVIDER OR SUPPLIER				RESS, CITY, STA	TE, ZIP CODE			
EXCELLE	NT ADULT CARE SERVI	CES	8280 HICK	AM AVE S, NV 89129				
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Y 920	Continued From page	e 6		Y 920				
	drawer in the kitchen; medications for Employe #1 were observed unlocked in the caregiver bedroom and the bedroom door was open).  This was a repeat deficiency from the 9/21/10 and 1/22/10 State Licensure surveys.							
		pe: 3						
Y 923 SS=F	3 449.2748(3)(b) Medication Container			Y 923				
			ny					
	Based on interview o keep medications be their original containe #4 - the owner of the the medication cups and Employee #1 ad to the residents. Em owner set up the med	ot met as evidenced by: n 3/8/11, the facility fail- longing to 4 of 4 resider er (Resident #1, #2, #3 a facility stated she preparate for the residents in advantaged the medication ployee #1 confirmed the dication cups with medicered them to the reside	ed to ints in and ared ance ons e cation					